

EXHIBIT 1

STATE OF INDIANA)
) SS:
 COUNTY OF MARION)
)
 MOISES VILLA and)
 MAYELA JIMENEZ,)
)
 Plaintiffs,)
)
 v.)
)
 THE ZURICH SERVICES)
 CORPORATION dba)
 ZURICH AMERICAN)
 INSURANCE COMPANY,)
)
 Defendant.)

COMPLAINT

COME NOW Plaintiffs Moises Villa and Mayela Jimenez (collectively, “Plaintiffs”), by counsel, and for their complaint against Defendant The Zurich Services Corporation dba Zurich American Insurance Company (“Defendant”) state and allege as follows:

PARTIES AND JURISDICTION

1. At all times relevant herein, Plaintiff Moises Villa (“Moises”) was an adult resident of Marion County, Indiana.
2. At all times relevant herein, Plaintiff Mayela Jimenez (“Mayela”) is an adult resident of Marion County, Indiana.
3. At all times relevant herein, and on information and belief, Defendant The Zurich Services Corporation dba Zurich American Insurance Company is an insurance company incorporated under the laws of the State of Illinois, having its principal place of business located at 1299 Zurich Way, Schaumburg, Illinois, and conducting business within the State of Indiana.

4. Jurisdiction and venue are proper in Marion County, Indiana pursuant to Indiana Rule of Trial Procedure 4.4(A)(1) and 4.4(A)(4), as well as 29 United States Code § 1132(e).

FACTS

5. Plaintiffs restate and reallege the allegations set forth in their rhetorical paragraphs 1 through 4 above as though fully written herein.
6. At all relevant times herein, Moises was a general laborer employed by St. Regis Culvert, Inc. (“SRC”).
7. At all relevant times herein, Moises’ mother, Mayela, was employed by the TJX Companies, Inc. (“TJX”), which held Accidental Death & Dismemberment Insurance Policy No. GTU 4379556 (the “AD&D Policy”) with Defendant. A true and accurate copy of the AD&D Policy is attached hereto as Exhibit “A”.
8. On or about July 2, 2018, Moises sustained injuries to his left hand and fingers while he was operating a metal roller press in the course and scope of his employment with SRC (the “Accident”).
9. Moises’ injuries were severe, resulting in the amputation of the entireties of his left index and middle fingers above their metacarpophalangeal joints, as well as the distal portion of his left thumb.
10. Following Moises’ Accident, Mayela filed Claim No. 7370067050 (the “Claim”) with Defendant, seeking dismemberment benefits under the AD&D Policy.
11. On May 6, 2019, Defendant sent a letter to Moises indicating that the Claim was denied because it did not believe the injuries he sustained as a result of the Accident were covered under the AD&D Policy. A true and accurate copy of Defendant’s letter dated May 6, 2019 is attached hereto as Exhibit “B”.

12. On July 3, 2019, Moises and Mayela, by counsel, appealed Defendant's denial of the Claim to Defendant's ERISA Appeal Committee (the "Committee"). A true and accurate copy of Plaintiffs' letter dated July 3, 2019 is attached hereto as Exhibit "C".
13. On August 26, 2019, the Committee affirmed the denial of the Claim. A true and accurate copy of Defendant's August 26, 2019 letter is attached hereto as Exhibit "D".

CLAIM FOR BENEFITS UNDER ERISA § 502(a)(1)(B)

14. Plaintiffs restate and reallege the allegations set forth in their rhetorical paragraphs 1 through 13 above as though fully written herein.
15. At all relevant times herein, both Villa and Jimenez were beneficiaries to the AD&D Policy issued to TJX by Defendant, both pursuant to the express language of the AD&D Policy itself and as defined by ERISA (29 U.S.C. § 1002).
16. The AD&D Policy provides accidental dismemberment benefits for the following:

Covered Loss of	Benefit
8. Thumb and Index Finger of the same Hand	25% of Principal Sum
For purposes of this benefit:	
1. Covered Loss means:	
b. Actual severance through or above the metacarpophalangeal joint of a thumb <u>OR</u> index finger.	

(emphasis added). Exhibit A, pp. 8-9.

17. Moises' Accident resulted in a Covered Loss (i.e, actual severance above the metacarpophalangeal joint of his left index finger).
18. Because Moises' Accident resulted in a Covered Loss, Moises is entitled and seeks to collect accidental dismemberment benefits as outlined in the AD&D Policy pursuant to ERISA § 502(a)(1)(B).

19. Defendant's failure and refusal to pay the benefits due to Moises as outlined in the AD&D Policy and pursuant to the express language thereof constitutes a violation of ERISA (29 U.S.C. § 1132).

20. Defendant's ERISA violation has damaged Plaintiffs in the form of unpaid accidental dismemberment benefits, as well as costs and attorneys' fees incurred in seeking the collection of those unpaid accidental dismemberment benefits in an amount yet to be fully determined.

WHEREFORE, Plaintiffs Moises Villa and Mayela Jimenez pray that the Court find in their favor and against Defendant The Zurich Services Corporation dba Zurich American Insurance Company on their claim; enter an award to Plaintiffs for 1) their unpaid benefits as outlined in the AD&D Policy; 2) Plaintiffs' attorneys' fees and costs pursuant to ERISA § 502(g) and Ind. Code § 34-52-1-1 in an amount yet to be fully determined; and 3) pre- and post-judgment interest at the statutory rate of eight percent (8.0%) per annum; and grant all other relief it deems just and proper in the premises.

Respectfully submitted,

/s/ Garrett M. Lewis
Garrett M. Lewis (#33803-71)
Attorney for Plaintiffs

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301 East 38th Street
Indianapolis, IN 46205
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75-237

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a copy of the foregoing was served upon the following via first class mail, sufficient postage affixed, and certified mail, return receipt requested and sufficient postage affixed on this 11th day of June, 2020:

The Zurich Services Corporation dba Zurich American Insurance Company
c/o Corporation Service Company, Registered Agent
135 North Pennsylvania Street, Suite 1610
Indianapolis, IN 46204

/s/ Garrett M. Lewis
Garrett M. Lewis (#33803-71)
Attorney for Plaintiffs

GOODIN ABERNATHY, LLP
301 East 38th Street
Indianapolis, IN 46205
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75-237



ZURICH

Certificate of Insurance

ZURICH AMERICAN INSURANCE COMPANY

Schaumburg, Illinois

Having issued **Accident Policy** Number GTU 4379556 to cover the eligible individuals of:

The TJX Companies, Inc.

Covered Subsidiaries or Affiliated Companies:

Sierra Trading Post

The insurance evidenced by this **Certificate** provides **ACCIDENT** insurance only. It does not provide **Coverage** for sickness. This **Certificate** describes the main features of the **Policy**, but the **Policy** is the only contract under which benefit payments are made. If there is an inconsistency between the **Certificate** and the **Policy**, the **Policy** will govern.

IMPORTANT NOTICE

**THIS INSURANCE PROVIDES ACCIDENT COVERAGE ONLY
THIS INSURANCE DOES NOT PROVIDE BENEFITS FOR SICKNESS**

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SECTION I – ELIGIBILITY AND EFFECTIVE DATES

CERTIFICATEHOLDER:

- Class I:** All non-union exempt associates working 30+ hours per week (including California non-exempt management associates) and all non-union non-exempt associates hired on or after October 1 2006 working 30 or more hours per week not included in any other **Class**.
- Class II:** All non-union TJ Maxx, AJ Wright, HomeGoods, Marmaxx and TJX associates hired prior to October 1, 1983 working their scheduled hours (no minimum hour requirement) not included in any other **Class**..
- Class III:** All non-union TJ Maxx, AJ Wright, HomeGoods, Marmaxx and TJX associates hired between October 1, 1983 and December 31, 1990 working 20+ hours per week not included in any other **Class**..
- Class IV:** All non-union Marshalls associates hired prior to May 1, 1988 working 16 or more hours per week not included in any other **Class**.
- Class V:** All non-union associates hired prior to October 1, 2006 (and who don't fall into one of the above **Classes**) working 24 or more hours per week not included in any other **Class**..
- Class VI:** All union associates in Atlanta, Bloomfield, Bridgewater, Fall River, Philadelphia, Pittston, South Bend and Woburn working their scheduled hours (no minimum hour requirement) not included in any other **Class**..
- Class VII:** All union associates in Brownsburg working 20 or more hours per week not included in any other **Class**..
- Class VIII:** All union associates in Pittston working 25 or more hours per week not included in any other **Class**..

An associate (including Union Associates) with a break in service of 13 weeks or less is eligible on the first day of their return.

Note: If **You** suffer an **Injury** resulting in a **Covered Loss** and **You** are covered under more than one class, **We** will pay only one benefit, the largest benefit.

ELIGIBILITY OF YOUR DEPENDENTS:

Individuals who enroll may elect to cover their eligible **Dependents**. An eligible **Dependent** includes **Your** legally married **Spouse/Same-Sex Domestic Partner** and **Your Dependent Child(ren)** and, **Your** legally married **Spouse's Dependent Child(ren)**, and **Your Same-Sex Domestic Partner's Dependent Child(ren)**. A legally married **Spouse/Same-Sex Domestic Partner** will not be eligible as a **Dependent** if he or she is also an **Insured** under the **Policy**. If **You** and **Your** legally married **Spouse/Same-Sex Domestic Partner**, legally separated **Spouse/Same-Sex Domestic Partner**, former **Spouse/Same-Sex Domestic Partner** are both **Insured's** under the **Policy**, only one may select a **Plan** covering their mutual **Dependents**.

SERVICE WAITING PERIOD:

- Store Hourly, District Office Hourly and Loss Prevention
Hourly Associates:90 days from date of hire/rehire
- Store Management; Home Office, California Loss Prevention
Investigators, Regional Office, Buying Office and Distribution/
Shipping Center - hourly and salaried Associates:30 days from date of hire/rehire
- Union Associates:As specified in union contract

YOUR EFFECTIVE DATE OF COVERAGE:

Coverage will become effective on the day the Associate meets the length of service requirement and properly enrolls in coverage.

MINIMUM HOURS REQUIREMENT

Associates must maintain the minimum hour requirement on an ongoing basis.

Hours will be monitored each calendar quarter. Associates who drop below the minimum hour requirement over two consecutive quarters will be cancelled effective the last day of the month following the end of that second quarter.

SECTION II – SCHEDULE**COVERAGES(S):****Classes Covered**24 Hour **Accident** Protection, Business and Pleasure,
Excluding Corporate Owned or Leased Aircraft, H-1

All

Exposure and Disappearance Coverage

All

Hijacking or Skyjacking Coverage

All

BENEFITS:**Classes Covered****ACCIDENTAL DEATH BENEFIT**

All

Principal Sum:**Class I:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class II:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class III:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class IV:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class V:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class VI:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class VII:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.**Class VIII:** You may purchase one of the following amounts of **Principal Sum:** \$10,000, 50,000, \$100,000 or \$200,000.The **Principal Sum** for **Covered Dependents** will be a percentage of the **Insured's Principal Sum**, as follows:

<u>Plan Selected</u>	<u>% Spouse/Same-Sex Domestic Partner</u>	<u>% Child(ren)</u>
Spouse/Same-Sex Domestic Partner only:	60%	0
Dependent Child(ren) only:	0	20%
Spouse/Same-Sex Domestic Partner and Dependent Child(ren)	60%	20%

Maximum of \$40,000 **Principal Sum** for **Dependent Child(ren)**.At age 70, for the **Insured** employee only, the **Principal Sum** will be reduced based on **Your previous Principal Sum** per the following schedule:

Age at Date of Loss	Percent of Principal Sum
70-74	65%
75-79	45%
80-84	30%
85 & Over	15%

**ACCIDENTAL DISMEMBERMENT AND COVERED
LOSS OF USE BENEFIT****Classes Covered**

All

Principal Sum:

Same as above.

Coma Benefit

All

ADDITIONAL BENEFITS:**Classes Covered**

Additional Dismemberment Benefit for Children

All

After School Care Benefit

All

COBRA Benefit

All

Common Disaster Benefit

All

Continuation of Insurance Benefit

All

Day Care Benefit

All

Felony Assault Benefit

All

Higher Education Benefit

All

Home Alteration and Vehicle Modification Benefit

All

Rehabilitation Benefit

All

Seat Belt/Air Bag Benefit

All

Spouse/Same-Sex Domestic Partner Retraining Benefit

All

Surviving Spouse/Same-Sex Domestic Partner Benefit

All

Therapeutic Counseling Benefit

All

Terrorism Benefit

All

Travel Assistance Plan

All

ADDITIONAL ENDORSEMENTS**Form Number****Classes Covered**

Vermont Civil Union Endorsement

U-VA-104-A (CW) (09/06)

All

SECTION III—DEFINITIONS

Accident or **Accidental** means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term.

Active and **Actively at Work** describes **You** if **You** are able and available for active performance of all of **Your** regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered **Actively at Work** provided **You** are able and available for active performance of all of **Your** regular duties and were working the day immediately prior to the date of **Your** absence.

Aggregate Limit of Liability means the total benefits **We** will pay for a **Covered Accident** or **Covered Accidents** set forth in the Schedule. For purposes of the **Aggregate Limit of Liability** provision, **Covered Accident** or **Covered Accidents** will include a **Covered Loss** or **Covered Losses** arising out of a single event or related events or originating cause and includes a resulting **Covered Loss** or **Covered Losses**. If the total benefits under the **Aggregate Limit of Liability** is not enough to pay full benefits to each **Covered Person**, **We** will pay each one a reduced benefit based upon the proportion that the **Aggregate Limit of Liability** bears to the total benefits which would otherwise be paid.

Certificate means this Certificate for the Group Accident Insurance Policy.

Chartered Aircraft means an aircraft operated by a company with an air carrier or commercial operating certificate issued by the Federal Aviation Administration or the equivalent certificate issued by a foreign government, which the **Policyholder** has the right to use for no more than ten (10) consecutive days and/or for no more than fifteen (15) days in a one (1) year period.

Controlled by, as used in the **Coverages** Section, means the **Policyholder** has the right to use a block of aircraft flight time for 25 or more hours in a one (1) year period or for 100 hours or more without a specified term, from a company which is in the business of providing aircraft for private use. A **Chartered Aircraft** will not be considered **Controlled by** the **Policyholder**.

Coverage(s) means the event or events described in the **Hazards** of the **Policy** to which benefits and additional benefits apply. The **Hazards** are listed in the **Coverages** Section on the Schedule.

Covered Accident means an **Accident** that results in a **Covered Loss**.

Covered Injury means an **Injury** directly caused by accidental means, which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under the **Policy**, and results in a **Covered Loss**.

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under the **Policy**.

Covered Person means any person who has insurance under the terms of the **Policy**. It includes **You** and **Your Spouse/Same-Sex Domestic Partner** and/or **Dependent Child(ren)** if **You** select a **Plan** covering **Your Spouse/Same-Sex Domestic Partner** and/or **Dependent Child(ren)**.

Dependent means **Your Spouse/Domestic Partner** and **Dependent Child(ren)**, as defined in this section. The **Dependent** will only be a **Covered Dependent** if a **Plan** covering **Dependents** is selected.

Dependent Child(ren), if used in the **Policy**, means **Your Child(ren)** who are less than 26 (twenty-six) years of age. **Coverage** will continue until the end of the month in which they turn 26 (twenty-six) years of age, or if prior to turning 26 (twenty-six) years of age, became incapable of self-sustaining employment by reason of mental retardation or physical handicap. The **Dependent Child(ren)** will only be **Covered Dependent Child(ren)** if a **Plan** covering **Dependent Child(ren)** is selected.

Injury means a bodily **Injury**.

Insured means an individual who is eligible for **Coverage** under the **Policy** as provided in the Certificateholder part of the **Eligibility and Classification of Insureds** Section, and who completes the enrollment material, if required.

Owned Aircraft means an aircraft in which the **Policyholder** or a related company has legal or equitable title. Fractional ownership in a company which is in the business of providing aircraft for private use will be deemed to be equitable title in the aircraft used by the **Policyholder**.

Plan means the **Plan** design as described on the Schedule.

Policy means the Group **Accident Insurance Policy**.

Policyholder means the group named on the front page of the **Policy**.

Service Waiting Period means the continuous length of time a person is required to be employed by the **Policyholder** prior to being covered under the **Policy**.

Specialized Aviation Activity means an aircraft while it is being used for one or more of the following activities:

acrobatic or stunt flying	hang gliding
aerial photography	hunting
banner towing	parachuting or skydiving
bird or fowl herding	pipe line inspection
crop dusting	power line inspection

crop seeding	racine
crop spraying	skywriting
endurance tests	test or experimental purpose
exploration	
fire fighting	
flight on a rocket-propelled or rocket launched aircraft	
flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted	

Same-Sex Domestic Partner means the definition of **Same-Sex Domestic Partner** in the **Policyholder's** medical plan is incorporated into the **Policy** as if the language had been inserted into the **Policy** and replaces any definition of **Same-Sex Domestic Partner** that currently exists in the **Policy**. Whenever the word "**Spouse**" is used in this **Policy**, it shall be understood to include a **Same-Sex Domestic Partner**.

Spouse, if used in the **Policy**, means **Your** legally married **Spouse** under age 70. **Your Spouse** will only be a **Covered Spouse** if a **Plan** covering **Your Spouse** is selected.

Under lease, as used in the **Coverages** Section, means an aircraft which the **Policyholder** does not own but has the right to use, under a written agreement, for more than ten (10) consecutive days and/or for more than fifteen (15) days in a one (1) year period. A **Chartered Aircraft** will not be considered **Under lease**.

We, Us, and Our refers to Zurich American Insurance Company.

You, Your refers to the **Insured**.

SECTION IV – COVERAGES

24 HOUR ACCIDENT PROTECTION, BUSINESS AND PLEASURE EXCLUDING CORPORATE OWNED OR LEASED AIRCRAFT, H-1

The **Hazards** insured against by the **Policy** are:

A **Covered Injury** sustained by a **Covered Person** anywhere in the world, subject to the terms, conditions, exclusions and limitations under the **Policy**.

Hazard Limitations:

Air travel **Coverage** is limited to a loss sustained during a trip, while the **Covered Person** is a passenger, riding in or on, boarding or getting off:

- A. any civilian aircraft with a current and valid normal, transport, or commuter type standard airworthiness certificate as defined by the Federal Aviation Administration or its successor or an equivalent certification from a foreign government. This aircraft must be operated by a pilot with a current and valid:
 1. medical certificate; and
 2. pilot certificate with a proper rating to pilot such aircraft
- B. any aircraft which is not subject to a certificate of airworthiness; whose design and customary and regular purpose is for transporting passengers; and which is operated by the Armed Forces of the United States of America or the Armed Forces of any foreign government.

Hazard Exclusions:

Coverage is not provided:

- A. If the **Covered Person** is the pilot, operator, member of the crew or cabin attendant of any aircraft.
- B. Unless **We** have previously consented in writing to the use, **Coverage** is not provided for any loss, caused by, contributed to, resulting from riding in or on, boarding, or getting off:
 1. any aircraft other than those expressly stated in this **Coverage**;
 2. any aircraft Owned or Controlled by, or Under lease to the **Policyholder**;
 3. any aircraft Owned or Controlled by, or Under lease to an **Insured** or a member of a **Covered Person's** family or household;

4. any aircraft operated by the **Policyholder** or one of the **Policyholder's** employees including members of an employee's family or household;
5. any aircraft engaged in a **Specialized Aviation Activity**;
6. any conveyance except aircraft used for tests or experimental purposes, or in a race or speed test.

Other Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

EXPOSURE AND DISAPPEARANCE COVERAGE

If a **Covered Person** is exposed to weather because of an **Accident** and this results in a **Covered Loss**, We will pay the applicable **Principal Sum**, subject to all **Policy** terms.

If the conveyance in which a **Covered Person** is riding disappears, is wrecked, or sinks, and the **Covered Person** is not found within 365 days of the event, We will presume that the **Covered Person** lost his or her life as a result of **Injury**. If travel in such conveyance was covered under the terms of the **Policy**, We will pay the applicable **Principal Sum**, subject to all **Policy** terms. We have the right to recover the benefit if We find that the **Covered Person** survived the event.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

HIJACKING or SKYJACKING COVERAGE

The exclusion for war or any acts of war whether declared or undeclared as found in section VII General Exclusions of the **Policy** is modified and **Covered Injuries** directly resulting from a **Hijacking** or **Skyjacking** or any attempt at any **Hijacking** or **Skyjacking** are covered under the **Policy**.

Hijacking or **Skyjacking** means the unlawful seizure or wrongful exercise of control of an aircraft or conveyance or the crew thereof, in which a **Covered Person** is traveling as a passenger.

This **Coverage** will continue beyond the actual **Hijacking** or **Skyjacking** while the **Covered Person** is:

1. subject to the control of the person(s) making the **Hijacking** or **Skyjacking**; and
2. traveling directly to his or her home or original destination.

Limitations and Exclusions that apply to this **Hazard** are in Section VII General Exclusions and Section VIII General Limitations.

SECTION V – BENEFITS

ACCIDENTAL DEATH BENEFIT

If a **Covered Person** suffers a loss of life as a result of a **Covered Injury**, We will pay the applicable **Principal Sum**. The death must occur within 365 days of the **Covered Injury**.

This benefit is subject to the limitations in Section VIII General Limitations.

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

If an **Injury** to a **Covered Person** results in any of the following **Covered Losses**, We will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based on the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of	Benefit
1. Both Hands or Both Feet	Principal Sum
2. One Hand and One Foot	Principal Sum
3. One Hand or One Foot plus the loss of Sight of One Eye	Principal Sum
4. Sight of Both Eyes	Principal Sum
5. Speech and Hearing	Principal Sum
6. Speech or Hearing	50% of Principal Sum
7. One Hand; One Foot; or Sight of One Eye	50% of Principal Sum
8. Thumb and Index Finger of the same Hand	25% of Principal Sum

Covered Loss of Use of

1. Four Limbs	Principal Sum
2. Three Limbs	75% of Principal Sum
3. Two Limbs	66 2/3% of Principal Sum
4. One Limb	50% of Principal Sum

For purposes of this benefit:

1. **Covered Loss** means:
 - a. For a foot or hand, actual severance through or above an ankle or wrist joint;
 - b. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
 - c. Total and permanent loss of sight;
 - d. Total and permanent loss of speech;
 - e. Total and permanent loss of hearing.
2. **Covered Loss of Use** means total paralysis of a **Limb** or **Limbs**, which is determined by **Our** competent medical authority to be permanent, complete and irreversible. **Limb** means an arm or a leg.

This benefit is subject to the limitations in Section VIII General Limitations.

COMA BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** within 365 days of a **Covered Accident**, and such **Injury** causes the **Covered Person** to be in a **Coma** for at least thirty-one (31) consecutive days, **We** will pay a **Coma Benefit**.

The **Coma Benefit** will be equal to 1% of the **Covered Person's Principal Sum** and will be paid each month the **Covered Person** remains in a **Coma** following the initial thirty-one (31) day period. The **Coma Benefit** will end on the earliest of the following:

1. when the **Covered Person** is no longer in a **Coma** which directly resulted from the **Injury**;
2. when the **Covered Person** has received a **Coma Benefit** for 100 months.

Coma will be determined by **Our** duly licensed physician.

This benefit is subject to the limitations in Section VIII General Limitations.

SECTION VI – ADDITIONAL BENEFITS

ADDITIONAL DISMEMBERMENT BENEFIT FOR CHILDREN

If **You** selected a **Plan** covering **Your** eligible **Dependent Child(ren)**, and a **Covered Dependent Child** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment Benefit**, **We** will pay **You** an additional benefit which will be equal to the benefit amount provided by the **Accidental Dismemberment Benefit** or \$50,000.

AFTER SCHOOL CARE BENEFIT

If **You** selected a **Plan** covering **Your Dependents** and **You** or **Your Covered Spouse/Same-Sex Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, **We** will reimburse the charges actually incurred for the after school care to the individual who incurs the expense for each **Covered Dependent Child**, who is ten (10) years old or less, up to a maximum of the lesser of:

1. 5% of the applicable **Principal Sum** paid under the **Accidental Death Benefit** per year; or
2. \$5,000 per year.

The after school care provider may not be a relative or family member and proof, acceptable to **Us** must be provided to establish eligibility for this benefit.

If **You** and **Your Covered Spouse/Same-Sex Domestic Partner** both die as a result of the same **Covered Injury**, and **We** pay an **Accidental Death Benefit** on both **Covered Persons**, only **Your Principal Sum** will be used to calculate the amount applicable under this benefit.

This benefit will be paid each year for four (4) consecutive years if the **Covered Dependent Child** is under age ten (10) at the time of each payment. The minimum amount payable under this benefit is \$1,500.

COBRA BENEFIT

If You selected a **Plan** covering **Your Dependents** and You suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, and You are covered under a medical plan sponsored by the **Policyholder**, We will pay an additional benefit to continue medical insurance for **Your** surviving family members for a period of one (1) year. The amount payable under this benefit will be the lesser of:

1. 5% of **Your Principal Sum**;
2. \$5,000; or
3. the actual cost to **Your** surviving family members to continue medical coverage for one (1) year under the plan sponsored by the **Policyholder**.

COMMON DISASTER BENEFIT

If You selected a **Plan** covering **Your Dependents** and You and **Your Covered Spouse/Same-Sex Domestic Partner** are both eligible for **Accidental Death Benefits** as a result of **Covered Injuries** suffered in the same **Accident** and within ninety (90) days of such **Accident**, the **Principal Sum** that would have been payable because of **Your Covered Spouse's/Same-Sex Domestic Partner's Accidental Death** will be increased to equal that payable for **Your** loss, provided:

1. You and **Your Covered Spouse/Same-Sex Domestic Partner** are survived by one or more **Covered Dependent Child(ren)**; and
2. the combined benefits of You and **Your Covered Spouse/Same-Sex Domestic Partner** are not more than \$700,000.

CONTINUATION OF INSURANCE BENEFIT

If You, selected a **Plan** covering **Your Dependents** and You suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, all **Coverages** under the **Policy** which were in force on the date of the loss, with respect to **Covered Persons** other than You, will be continued automatically for 365 days after the date of the loss at no additional cost.

DAY CARE BENEFIT

If You selected a **Plan** covering **Your Dependents** and You or **Your Covered Spouse/Same-Sex Domestic Partner** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, We will pay an additional benefit for day care expenses to the individual who incurs the expense on behalf of each **Covered Dependent Child** if:

1. on the date of the **Accident**, the **Covered Dependent Child** was enrolled in an **Accredited Child Care Facility**, or enrolls in such facility within ninety (90) days from the date of loss; and
2. the **Covered Dependent Child** is under age 13.

The **Day Care Benefit** will be equal to the lesser of:

1. the actual cost of the child care;
2. 5% of the **Covered Person's Principal Sum** who suffered the **Covered Loss**; or
3. \$5,000.

If both You and **Your Covered Spouse/Same-Sex Domestic Partner** suffer a simultaneous **Covered Loss**, the **Day Care Benefit** will be based on **Your Principal Sum**.

The **Day Care Benefit** will be paid annually for four (4) consecutive years if:

1. the **Covered Dependent Child** is under age 13 at the time of each annual payment; and
2. proof, acceptable to Us, is received by Us that verifies that the **Covered Dependent Child** remains enrolled in an **Accredited Child Care Facility**.

An **Accredited Child Care Facility** means:

1. a child care facility that operates pursuant to state and local laws;
2. is licensed by the state for such child care facilities; and
3. has been provided with a Tax Identification Number by the Internal Revenue Service.

An **Accredited Child Care Facility** does not include a hospital; the child's home; a nursing or convalescent home; a facility for the treatment of mental disorders; an orphanage; or a treatment center for drug and alcohol abuse.

The minimum amount payable under this benefit is \$1,500.

FELONIOUS ASSAULT BENEFIT

If You suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit** or **Accidental Dismemberment and Covered Loss of Use Benefit** as a result of a violent or criminal act committed by someone other than You, a **Fellow Employee** or a member of Your **Family** or **Household**, We will pay an additional benefit equal to 15% of Your **Principal Sum**, provided:

1. the **Injury** is incurred in connection with the **Policyholder's** normal business whether on or off the **Policyholder's** premises; and
2. the crime directly involves the **Policyholder's** funds or assets.

For purposes of this benefit:

Fellow Employee means a person employed by the same employer as You or by an employer that is an affiliated or subsidiary corporation. It will also include any person who was so employed, but whose employment was terminated not more than forty-five (45) days prior to the date on which the defined violent crime/felonious assault was committed.

Family means Your parent, step-parent, **Spouse** or former **Spouse**, son, daughter, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild or stepchild.

Household means a person who maintains residence at the same address as You.

This benefit applies only to the crimes or attempted crimes of robbery, theft, hold-up or kidnapping.

HIGHER EDUCATION BENEFIT

If You selected a **Plan** covering Your **Dependent Child(ren)** and You suffer an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, We will pay an additional benefit for higher education expenses to the individual who incurs the expense for each **Covered Dependent Child**.

A **Covered Dependent Child** is eligible for the **Higher Education** benefit if on the date of the **Accident**:

1. he or she is enrolled as a full-time student in an accredited college, university or trade school; or
2. he or she was at the 12th grade level and enrolls in an accredited college, university or trade school within one (1) year from the date of the **Accident**.

The **Higher Education** will be equal to 5% of Your **Principal Sum**. This amount will be paid annually for four (4) consecutive years if Your **Covered Dependent Child** continues his or her education. Before this benefit is paid each year, Your **Covered Dependent Child** must present written proof, acceptable to Us, that he or she is attending an institution of higher learning on a full-time basis.

The maximum amount payable for this benefit is \$15,000.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, We will pay an additional benefit for home alterations and/or vehicle modifications, provided:

1. the **Covered Person** is required to use a wheelchair to be ambulatory on a permanent basis; and
2. the **Injury** that caused the payment of the **Accidental Dismemberment and Covered Loss of Use Benefit** is the same **Injury** that requires the **Covered Person** to need the wheelchair.

The amount We will pay will be equal to:

1. the one time cost of alterations to the **Covered Person's** primary residence to make it wheelchair accessible and habitable; and
2. the one time cost of modifications necessary to his or her motor vehicle to make the vehicle accessible or drivable.

Benefits will not be payable unless:

1. alterations and/or modifications are made by a person or persons experienced in such alterations and/or modifications, and are recommended by a recognized organization providing support and assistance to wheelchair users; and
2. ~~presentation of proof of payment is provided to Us.~~

The maximum amount payable under all provisions of this benefit combined will be the lesser of 10% of the **Covered Person's Principal Sum** or \$10,000.

REHABILITATION BENEFIT

If **You** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Dismemberment and Covered Loss of Use Benefit**, **We** will pay an additional benefit for the **Reasonable and Customary** expenses actually incurred for **Rehabilitation Training** in an amount equal to the lesser of:

1. the actual expenses that are incurred within two (2) years from the date of the **Accident** for the **Rehabilitation Training**;
2. \$10,000; or
3. 10% of **Your Principal Sum**.

Rehabilitation Training means a treatment program that:

1. is prescribed by a licensed physician acting within the scope of his or her license that is approved by **Us** prior to the provision of services;
2. is required due to **Your Injury**; and
3. prepares **You** for an occupation which **You** would not have engaged in except for the **Injury**.

Reasonable and Customary expenses means the common charges made by other health care providers in the same locality for the treatment furnished. If the common charges for a service cannot be determined due to the unusual nature of such service, **We** will determine the amount based upon:

1. the complexity involved;
2. the degree of professional skill required; and
3. any other pertinent factors.

We reserve the right to make the final determination of what is **Reasonable and Customary**.

SEAT BELT/AIR BAG BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss**, which is payable under the **Accidental Death Benefit**, and the **Injury** which caused the accidental death directly resulted from an automobile **Accident**, **We** will pay to the beneficiary an additional benefit, which equals 10% of the applicable **Principal Sum** up to a maximum of \$25,000, provided that the **Covered Person** was:

1. operating or riding as a passenger in any private passenger automobile designed for use primarily on public roads; and
2. wearing an original, equipped, factory installed or manufacturer authorized and unaltered seat belt, or lap and shoulder restraint at the time of the **Injury**.

Verification of the **Covered Person's** actual use of the seat belt or lap and shoulder restraints is required as follows:

1. in the official law enforcement report of the **Accident**, through certification by the investigating officers; or
2. by other reasonable proof, acceptable to **Us**.

An additional benefit equal to 10% of the **Covered Person's Principal Sum** to a maximum of \$10,000, will be paid if the **Covered Person** was driving a private passenger automobile with a manufacturer equipped driver-side air bag or riding as a passenger in a private passenger automobile with a manufacturer equipped passenger-side air bag, provided the **Covered Person's** seat belt or lap and shoulder restraint was properly fastened at the time of the **Accident**. The proper functioning and/or deployment of the air bag must be certified in the official law enforcement report of the **Accident**, through certification by the investigating officers or by other reasonable proof, acceptable to **Us**.

We will not pay a **Seat Belt or Air Bag Benefit** if the driver of the private passenger automobile in which the **Covered Person** was riding was either:

1. under the influence of alcohol;
 - a. A driver will be conclusively presumed to be under the influence of alcohol if the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be under the influence of alcohol or intoxicating liquor if operating a motor vehicle.
 - b. An autopsy report from a licensed medical examiner, law enforcement officer reports, or similar items will be considered proof of the driver's intoxication. Or,
2. under the influence of any prescription drug, narcotic, or hallucinogen, unless such prescription drug, narcotic, or hallucinogen was prescribed by a physician and taken in accordance with the prescribed dosage.

SPOUSE/SAME-SEX DOMESTIC PARTNER RETRAINING BENEFIT

If You selected a **Plan** covering Your **Spouse/Same-Sex Domestic Partner** and You suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, We will pay to, or on behalf of, Your **Covered Spouse/Same-Sex Domestic Partner**, the actual cost of any professional or trade-training program in which the **Covered Spouse/Same-Sex Domestic Partner** enrolls, provided:

1. the purpose of the training program is to obtain an independent source of support and maintenance;
2. the actual cost is incurred within thirty (30) months from Your death; and
3. the professional or trade training program is licensed by the state.

The maximum amount payment under this benefit will be a minimum of \$2,500 to a maximum of \$5,000.

SURVIVING SPOUSE/SAME-SEX DOMESTIC PARTNER BENEFIT

If You selected a **Plan** covering Your **Spouse/Same-Sex Domestic Partner** and You suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death Benefit**, We will pay an additional benefit to Your **Covered Spouse/Same-Sex Domestic Partner**. The monthly benefit will be equal to 1% of Your **Principal Sum** and will be paid for a period of six (6) months.

TERRORISM BENEFIT

If a **Covered Person** suffers an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit** that was directly caused by an **Act of Terrorism**, We will pay an additional benefit equal to the lesser of 10% of the **Covered Person's Principal Sum** or \$30,000.

Act of Terrorism means any intentionally violent or forceful act of any person(s), acting on behalf of an organization or group, with the purpose of creating political turmoil or overthrowing any government.

We may cancel this **Terrorism Benefit** by sending the **Policyholder**, at its most recent address in Our records, a ten (10) day notice of Our intent to cancel. Upon cancellation, We will return any unearned premium that the **Policyholder** has paid, but this is not a condition of termination. A change or termination in this benefit will not affect a claim which begins while this benefit is in force.

THERAPEUTIC COUNSELING BENEFIT

If You selected a **Plan** covering Your **Dependents** and You or Your **Covered Dependents** suffer an **Injury** resulting in a **Covered Loss** which is payable under the **Accidental Death** or **Accidental Dismemberment and Covered Loss of Use Benefit**, and You or Your **Covered Dependents** require **Therapeutic Counseling**, We will reimburse the actual expense for such counseling to the individual who incurs the expense, provided:

1. all terms and conditions of the **Policy** are met;
2. **Therapeutic Counseling** begins within ninety (90) days of the **Covered Accident**;
3. **Therapeutic Counseling** must be incurred within one year from the date of the **Covered Loss**.

Therapeutic Counseling means treatment or counseling provided by a licensed therapist or counselor who is registered or certified to provide psychological treatment or counseling.

The amount payable under this benefit for any one **Covered Accident** will be the lesser of 5% of the **Covered Person's Principal Sum** or \$5,000.

TRAVEL ASSISTANCE PLAN

This **Travel Assistance Plan** will apply to the following **Covered Persons** when they are traveling 100 miles or more from their **Principal Residence**: the **Insured** and his or her **Spouse/Same-Sex Domestic Partner** and/or **Child(ren)**, if covered under the **Policy**. The transportation and/or services provided under this **Travel Assistance Plan** must be pre-authorized by Us. Under the **Policy**, the **Travel Assistance Plan** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which based upon Our evaluation cannot provide medical care in accordance with **Western Medical**

Standards, We will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician.

For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider.

Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a non-scheduled commercial air flight or a regularly scheduled air flight with special equipment and/or personnel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to his or her **Principal Residence** or to his or her residence in the country where he or she is currently assigned (at his or her option) in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. No transport will be arranged for and/or covered without the prior recommendation of the attending physician. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel which are covered.

Non-Medical Repatriation

If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel in a regularly scheduled economy class air flight without special equipment or personnel with minimal risk to his or her health, **We** will pay for the increase in cost to change the travel date on the return air flight and/or for an upgrade in the seating to his or her **Principal Residence** or to the country where he or she is currently assigned (at his or her option). **We** must be contacted prior to the transport and **We** must agree to the change in the travel date and/or upgrade for benefits to be payable which is also subject to the prior recommendation of the attending physician. The upgrade will be subject to **Our** sole discretion.

Return of Remains

If a **Covered Person** dies while on a **Covered Trip**, **We** will pay and make arrangements for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable.

Visit to Hospital

If a **Covered Person** is scheduled to be hospitalized for more than seven (7) consecutive days while on a **Covered Trip**, **We** will arrange for, and cover the cost of, a regularly scheduled round trip economy class air flight of the person chosen by the **Covered Person** to visit the **Covered Person** while he or she is hospitalized. **We** must pre-authorize the transportation for benefits to be payable.

Return of Child

If a **Covered Person** is traveling with a **Child** who is under nineteen (19) years of age or a **Child** who prior to age nineteen (19) became incapable of self-sustaining employment by reason of mental retardation or physical handicap and remains chiefly dependent upon the **Covered Person** for support and maintenance while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** such **Child(ren)** is left unattended, **We** will arrange for, and cover the cost of, the transport of the **child(ren)** by a regularly scheduled economy class air flight to the location chosen by the **Covered Person** and for an attendant, if applicable. **We** must pre-authorize the transportation of the **Child(ren)** and attendant, if applicable, for benefits to be payable.

Return of Companion

If a **Covered Person** is traveling with a companion while on a **Covered Trip** and due to the **Illness** or **Injury** to the **Covered Person** the **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the lesser of the change fee for the companion's return air flight or a one way economy class flight, whichever is less. **We** must pre-authorize such costs for benefits to be payable.

• **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide the **Travel Assistance Plan** if the **Coverage** is excluded under Section VII – General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from the **Covered Person** being under the influence of any controlled substance, unless such controlled substance was prescribed by a physician and was taken in accordance with the prescribed dosage;
3. with respect to a **MEDICAL EVACUATION**, the medical care which is being provided is consistent with **Western Medical Standards**. We have sole discretion in making that determination;
4. with respect to **MEDICAL EVACUATION**, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. We have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, We determine that **MEDICAL EVACUATION** or **MEDICAL REPATRIATION** is not appropriate. We have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this coverage. We will be fully and completely excused from performance and discharged from any contractual obligation;
7. We did not pre-authorize the transportation and/or services.

• **TRAVEL ASSISTANCE DEFINITIONS**

For purposes of this **Travel Assistance Plan** only, the following definitions apply:

“**Covered Trip**” means when a **Covered Person** is traveling more than 100 miles from his or her **Principal Residence** and such travel is covered under the **Policy** and is not excluded under the **TRAVEL ASSISTANCE EXCLUSIONS** set above.

“**Illness**” or “**Ill**” means a sickness or disease which impairs normal functions of the body.

“**Injured**” “**Injury**” or “**Injuries**” means a bodily **Injury** or **Injuries** and is not limited to accidental bodily injuries.

“**Principal Residence**” means the legal domicile of the **Covered Person**.

“**Western Medical Standards**” means generally accepted medical standards comparable to those in the United States, Canada or Western Europe.

For the purpose of the **Travel Assistance Plan**, if there are any differences in the definition of a term between the **Travel Assistance Plan** and the **Policy**, the definition in the **Travel Assistance Plan** will govern.

• **TRAVEL ASSISTANCE - OTHER PROVISIONS**

Right of Recovery

We have the right to recover any benefits which We have paid under this **Travel Assistance Plan** if the **Policyholder** or **Covered Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Covered Person** which were covered under this **Travel Assistance Plan**. We will be reimbursed from such recovery and We will have a lien against that recovery. We have the right to recover any benefits from the **Covered Person** for transportation services and/or expenses, which were not covered under the **Travel Assistance Plan**.

Reservation of Rights

We reserve the right to suspend, curtail or limit Our coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit Us to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.

Scope

Illness, as covered under the **Travel Assistance Plan**, is solely covered under the **Travel Assistance Plan**, and in no way supersedes or modifies the other benefits provided under the **Policy**.

To contact Us regarding the **Travel Assistance Plan**, the **Covered Person** must call 1-800-263-0261 from the U.S. or Canada; and collect from anywhere else in the world at +1-416-977-0277.

SECTION VII – GENERAL EXCLUSIONS

A loss will not be a **Covered Loss** if it is caused by, contributed to, or results from:

1. intentionally self-inflicted **Injury**, suicide or attempted suicide, whether sane or insane;
2. war or act of war, whether declared or undeclared;
3. **Injury** sustained while full-time in the armed forces of any country or international authority;
4. illness or disease, regardless of how contracted; medical or surgical treatment of illness or disease; or complications following the surgical treatment of illness or disease; except for **Accidental** ingestion of contaminated foods;
5. **Injury** sustained while riding on any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6. **Injury** sustained while riding on any aircraft:
 - a. as a pilot, crew member or student pilot;
 - b. as a flight instructor or examiner; or
 - c. if it is owned, operated or leased by or on behalf of the **Policyholder**, or any employer or organization whose eligible persons are covered under this **Policy**;
7. **Injury** sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens unless the drug is taken as prescribed or administered by a licensed physician;
8. **Injury** sustained as a result of being legally intoxicated from the use of alcohol;
9. **Injury** sustained while committing or attempting to commit a felony.

SECTION VIII – GENERAL LIMITATIONS

Limitation on Multiple Covered Losses. If a **Covered Person** suffers more than one loss as a result of the same **Accident**, **We** will pay only one benefit, the largest benefit.

Limitation on Multiple Benefits. If a **Covered Person** can recover benefits under more than one of the following benefits: **Accidental Death Benefit**, **Accidental Dismemberment** and **Covered Loss of Use Benefit**, **Coma Benefit** as a result of the same **Accident**, the most **We** will pay for these benefits in total is the **Covered Person's Principal Sum**.

Limitation on Multiple Hazards. If a **Covered Person** suffers a **Covered Loss** that is covered under more than one **Hazard**, **We** will pay only one benefit, the largest benefit.

SECTION IX - TERMINATION OF INSURANCE

Your Insurance. **Your** insurance terminates at the end of thirty-one (31) days after **Your** employment has been terminated for which premium has been paid and during which any of the following occurs:

1. the **Policy** is terminated;
2. **You** cease to be eligible for insurance;
3. **You** fail to pay the required premium, if **You** are so required;
4. **You** retire.

Your Covered Dependent's Insurance. Insurance terminates on the earliest of:

1. the date **Your** insurance terminates;
2. the first premium due date after **Your Covered Dependent** no longer qualifies as a **Covered Person**;
3. for **Your Covered Spouse/Same-Sex Domestic Partner**, the date **Your Covered Spouse/Same-Sex Domestic Partner** reaches age 70.

Conversion Privilege

If **Your** insurance ceases for reasons other than termination of the **Policy** or nonpayment of premium, **You** are entitled to convert **Your Coverage** to an **Individual Accidental Death or Dismemberment (IAD)** policy or to a **Family AD&D (FAD)** policy if **You** selected a **Plan** covering **Your Dependents**. The new **IAD** or **FAD** policy will be on approved forms and will not include all the **Benefits** and **Additional Benefits** of the **Group Accident Policy**. **You** must make a written application for the **IAD** or **FAD** policy within sixty (60) days of the cessation of **Your** insurance under the **Group Accident Policy**. To request a **Conversion Application Form**, **You** must call 1-800-834-1959. **You** do not have to show proof of good health.

The issuance of the **IAD** or **FAD** policy is subject to the following conditions:

1. The **Principal Sum** for the **IAD** or **FAD** policy will be the lesser of **Your Principal Sum** under the Group **Accident Policy** or \$250,000;
2. The premium for the **IAD** or **FAD** policy will be the rate on file with the proper regulatory authority, if such filing is required;
3. Any **IAD** or **FAD** policy issued will take effect on the termination date of **Your** insurance under the Group **Accident Policy**; and
4. When an **IAD** or **FAD** policy becomes effective, the relationship between **You** and **Us** will be governed by that policy, including all terms and conditions, including benefits and termination dates.

The **Conversion Privilege** will cease when **You** attain age 70.

SECTION X - HOW TO FILE A CLAIM

- A. **Notice.** **You** or **Your** beneficiary, or someone on **Your** behalf, must give **Us** written notice of the **Covered Loss** within ninety (90) days of such **Covered Loss**. The notice must name the **Covered Person** who sustained the **Injury**, **You**, and the **Policy Number**. To request a claim form, **You** or **Your** beneficiary, or someone on **Your** behalf may contact **Us** at 1-866-841-4771. The notice must be sent to the Claims Department, Zurich American Insurance Company, P.O. Box 968041, Schaumburg, IL 60196-8041, or any of **Our** agents. Notice to **Our** agents is considered notice to **Us**.
- B. **Claim Forms.** **We** will send the claimant proof of **Covered Loss** forms within fifteen (15) days after **We** receive notice. If the claimant does not receive the proof of **Covered Loss** form in fifteen (15) days after submitting notice, he or she can send **Us** a detailed written report of the claim and extent of **Covered Loss**. **We** will accept this report as a proof of **Covered Loss** if sent within the time fixed below for filing a proof of **Covered Loss**.
- C. **Proof of Covered Loss.** Written proof of **Covered Loss**, acceptable to **Us**, must be sent within ninety (90) days of the **Covered Loss**. Failure to furnish proof of **Covered Loss** acceptable to **Us** within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of **Covered Loss** and the proof was provided as soon as reasonably possible.

SECTION XI - PAYMENT OF CLAIMS

- A. **Time of Payment.** **We** will pay claims for all **Covered Losses**, other than **Covered Losses** for which the **Policy** provides any periodic payment, immediately upon receipt of written proof of loss that is acceptable to **Us**. Unless an optional periodic payment is stated or chosen, any **Covered Loss** to be paid in periodic payments will be paid at the end of each four-week period. The unpaid balance, which remains when **Our** liability ends, will then be paid when **We** receive the proof of **Covered Loss** that is acceptable to **Us**.
- B. **Who We Will Pay.**
 1. **Your Loss of Life.** **Covered Losses** resulting from **Your** death are paid to the named beneficiary at the time of death. If there is no beneficiary named or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to the beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy. If there is no beneficiary named by **You** for the **Policyholder's** Group Life Insurance policy, or the named beneficiary predeceases or dies at the same time as **You**, **We** will pay the benefit to **Your** survivors in the following order:
 - a. **Your** legally married Spouse or Same-Sex Domestic Partner;
 - b. **Your** Child(ren);
 - c. **Your** parents;
 - d. **Your** brothers and sisters;
 - e. **Your** estate.
 2. **Loss of Life of Your Covered Dependent.** **Covered Losses** for the death of **Your Covered Dependent** will be paid to **You**. If **You** pre-decease or die at the same time as **Your Covered Dependent**, the benefit will be paid to the beneficiary unless the beneficiary designation has not been made or the beneficiary is no longer living at the time of death. In such case, the benefits will be paid to **Your** estate.
 3. **All Other Claims.** Benefits are to be paid to the **Covered Person**.

- C. **Physical Examination and Autopsy.** We have the right to examine a **Covered Person** when and as often as We may reasonably request while the claim is pending. Such examination will be at **Our** expense. We can have an autopsy performed unless forbidden by law.
- D. **Choice of Service Provider.** The **Covered Person** has the sole right to choose his or her duly licensed physician and hospital.

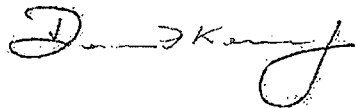
SECTION XII - GENERAL POLICY CONDITIONS

- A. **Beneficiaries.** You have the sole right to name a beneficiary. The beneficiary has no interest in the **Policy** other than to receive certain payments. You may change the beneficiary at any time unless You have assigned the interest in the **Policy**. In such case, the person to whom You have assigned the interest in the **Policy** may have the right to change the beneficiary. Consent to a change by a prior beneficiary is not needed unless the previous beneficiary was designated as irrevocable. Any beneficiary designation must be in writing on a form acceptable to Us.
- B. **Change or Waiver.** A change or waiver of any terms or conditions of the **Policy** must be issued by Us in writing and signed by one of **Our** executive officers. No agent has authority to change or waive **Policy** terms or conditions. A failure to exercise any of **Our** rights under the **Policy** will not be deemed as a waiver of such rights in the same or future situations.
- C. **Clerical Error.** A clerical error or omission will not increase or continue **Your Coverage** which otherwise would not be in force. If You apply for insurance for which You are not eligible, We will only be liable for any premiums paid to Us.
- D. **Conformity with Statute.** Terms of the **Policy** that conflict with the laws of the state where it is delivered are amended to conform to such laws.
- E. **Suit Against Us.** No action on the **Policy** may be brought until sixty (60) days after written proof of **Covered Loss** has been sent to Us. Any action must commence within three (3) years, (five (5) years in Kansas and Tennessee; and six (6) years in South Carolina and Wisconsin) of the date the written proof of **Covered Loss** was required to be submitted. If the law of the state where the **Covered Person** lives makes such limit void, then the action must begin within the shortest time period permitted by law. In those states where binding arbitration is allowed, binding arbitration will supersede this provision.
- F. **Assignment of Interest.** A transfer of interest is binding when We receive written notice on a form acceptable to Us. We have no duty to confirm that a transfer is valid.
- G. **Arbitration.** Any contest to a claim denial under the **Policy** will be settled by arbitration administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules, and judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction. The arbitration will occur at the offices of the American Arbitration Association nearest to the **Covered Person**. The arbitrator(s) will not award consequential or punitive damages in any arbitration under this section. This provision does not apply if the **Covered Person** is a resident of a state where the law does not allow binding arbitration in an insurance policy, but only if the **Policy** is subject to its laws. In such a case, binding arbitration does not apply. This provision bars the **Covered Person** from instituting a lawsuit.

In Witness Whereof, We have caused the **Policy** to be executed and attested, and, if required by state law, the **Policy** will not be valid unless countersigned by **Our** authorized representative.



Mark E. Knipfer
President
Zurich American Insurance Company



Dennis Kerrigan
Corporate Secretary
Zurich American Insurance Company

NON-PARTICIPATING

The TJX Companies, Inc.
GTU 4379556
Effective: August 1, 2018

Version: March 2019

SANCTIONS EXCLUSION ENDORSEMENT



THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY

The following exclusion is added to the policy to which it is attached and supersedes any existing sanctions language in the policy, whether included in an Exclusion Section or otherwise:

SANCTIONS EXCLUSION

Notwithstanding any other terms under this policy, we shall not provide coverage nor will we make any payments or provide any service or benefit to any insured, beneficiary, or third party who may have any rights under this policy to the extent that such coverage, payment, service, benefit, or any business or activity of the insured would violate any applicable trade or economic sanctions law or regulation.

The term policy may be comprised of common policy terms and conditions, the declarations, notices, schedule, coverage parts, insuring agreement, application, enrollment form, and endorsements or riders, if any, for each coverage provided. Policy may also be referred to as contract or agreement.

We may be referred to as insurer, underwriter, we, us, and our, or as otherwise defined in the policy, and shall mean the company providing the coverage.

Insured may be referred to as policyholder, named insured, covered person, additional insured or claimant, or as otherwise defined in the policy, and shall mean the party, person or entity having defined rights under the policy.

These definitions may be found in various parts of the policy and any applicable riders or endorsements.

ALL OTHER TERMS AND CONDITIONS OF THIS POLICY REMAIN UNCHANGED



Privacy Notice

We Take Important Steps to Protect the Personal Information We Collect About You

Dear Customer:

rev. October 2016

We care about your privacy. That is why we believe in your right to know what nonpublic personal information we collect about you and what we do with that information. This Privacy Notice describes the nonpublic personal information we collect about you and how we handle the information as it relates to individuals who either own or are covered by insurance we issue, or who use other financial products or services we provide.

Overview	UNDERSTANDING HOW WE USE YOUR PERSONAL INFORMATION
Why are you receiving this Notice?	<p>Financial institutions, which include the Company, choose how they share your personal nonpublic information. Federal and state law gives consumers the right to limit some but not all sharing of that information. Federal law also requires us to tell you how we collect, share and safeguard your nonpublic personal information. You are receiving this Privacy Notice because our records show either that you are the owner of an insurance policy or you are (or are authorized to act on behalf of) a current insured, future beneficiary and/or claimant under a policy, product or services issued by the Company.</p>
What types of information do we collect?	<p>The types of nonpublic personal information we collect and share depend on the product or service you have with us. For example, this information can include:</p> <ul style="list-style-type: none"> • Information about you we receive from you on applications or other forms, such as your name, address, telephone number, date of birth, your social security number, employment information, information about your income, medical information; • Information about your transactions with the Company and its affiliates; • Information about your claims history; • Data from insurance support organizations, government agencies, insurance information sharing bureaus; • Property information and similar data about you or your property; and • Information we receive from a consumer reporting agency, such as a credit report. <p>When your relationship with us ends, we may continue to share information about you as described in this Privacy Notice.</p>
What do we do with the nonpublic personal information we collect?	<p>WE SHARE YOUR NONPUBLIC PERSONAL INFORMATION IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS OR SERVICES, AS AUTHORIZED BY LAW, OR WITH YOUR CONSENT. THIS INCLUDES SHARING, AS PERMITTED BY LAW, YOUR NONPUBLIC PERSONAL INFORMATION WITH AFFILIATED PARTIES AND NONAFFILIATED THIRD PARTIES, AS APPLICABLE, IN THE COURSE OF SUPPORTING YOUR INSURANCE COVERAGE OR NON-INSURANCE PRODUCTS. IN THE SECTION BELOW, WE LIST THE REASONS WE CAN SHARE YOUR NONPUBLIC PERSONAL INFORMATION, WHETHER WE ACTUALLY SHARE YOUR NONPUBLIC PERSONAL INFORMATION, AND WHETHER YOU CAN OPT OUT OF THIS SHARING (OR IF YOU ARE A RESIDENT OF VERMONT, WHETHER YOU HAVE THE RIGHT TO OPT IN TO ALLOWING THIS SHARING).</p>

Reasons we may share your personal information	Does Company Share?	Can you opt out of this sharing or limit this sharing or is your authorization required for this sharing?
For our everyday business purposes – to affiliates and non-affiliates to process your transactions, administer insurance coverage, products or services, maintain your account and report to credit bureaus	Yes	No
For our marketing purposes or for joint marketing with other financial companies	No	We don't share
For our affiliates' everyday business purposes – transaction and experience information	Yes	No
For our affiliates' everyday business purposes – creditworthiness	No	No
For our affiliates to market to you	Yes	No
For non-affiliates to market to you	No	We don't share

Collecting and safeguarding information	
How often does the Company notify me about their practices?	We must notify you about our sharing practices when you receive your policy, open an account or purchase a service, and each year while you are a customer, or when significant or legal changes require a revision.
Why and how does the Company collect my nonpublic personal information?	<p>We collect nonpublic personal information when you apply for insurance or file an insurance claim to help us provide you with our insurance products and services, and determine your insurability or other eligibility. We may also ask you and others for information to help us verify your identity in order to prevent money laundering and terrorism. We collect personal information from:</p> <ul style="list-style-type: none"> • Applications, forms and telephone, web site or written contact with you. This information can include social security number, driver's license number and income. • Your transaction(s) with us, our affiliates and other non-affiliated third parties. Transactional information includes such things as your insurance coverage, premiums, claims and payment history. Non-affiliated third parties may include appraisers, investigators, insurance companies, etc. • Information from physicians, hospitals and other medical providers. We collect this information only in connection with the issuance of individual or group insurance policies on your life or health, and with the processing and adjustment of claims under that insurance. <p>Information in a report prepared by an insurance support organization may be retained by that organization and provided to others.</p>
What nonpublic personal information does the Company disclose?	We may provide to an affiliated or non-affiliated party the same nonpublic personal information listed above in the section entitled, "What information do we collect?"

How does the Company safeguard my nonpublic personal information?	Employees who have access to your nonpublic personal information are required to maintain and protect the confidentiality of that information. Access to your personal information may be needed to conduct business on your behalf or to service your insurance coverage. In addition, we maintain physical, electronic and procedural measures to protect your personal information in compliance with applicable laws and regulatory standards.
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FOR RESIDENTS OF ARIZONA, CALIFORNIA, CONNECTICUT, GEORGIA, ILLINOIS, MAINE, MASSACHUSETTS, MINNESOTA, MONTANA, NEW JERSEY, NEVADA, NORTH CAROLINA, OHIO, OREGON, OR VIRGINIA:

You have the following individual rights under state law:

Except for certain documents related to claims and lawsuits, you have the right to access the recorded personal information that we have collected about you which we reasonably can locate and retrieve. To access your recorded personal information you must submit a written request reasonably describing the information you seek, and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com. If you would like a copy of your recorded personal information that we reasonably can locate and retrieve, we may charge you a reasonable fee to cover the costs incurred in providing you a copy of the recorded information. If you request medical records, we may elect to supply that information to you through your designated medical professional. We may also direct you to a consumer reporting agency to obtain certain consumer report information.

Generally, most of the recorded nonpublic personal information we collect about you and have in our possession is from policy applications or enrollment forms you submit to obtain our products and services, and is reflected in your statements and other documentation you receive from us. If you believe that the personal information we have about you in our records is incomplete or inaccurate, please let us know at once in writing, and we will investigate and correct any errors we find.

You also have the right to request the correction, amendment, or deletion of recorded personal information about you that we have in our possession. You must make your request in writing and send your written request to: Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.

FOR RESIDENTS OF MASSACHUSETTS ONLY: You may ask in writing for the specific reasons for an adverse underwriting decision. An adverse underwriting decision is where we decline your application for insurance, offer to insure you at a higher than standard rate or terminate your coverage.

Key words and phrases	TERMS YOU SHOULD KNOW
Definitions	
Everyday business purposes	The actions necessary for financial companies like the Company to conduct business and manage customer accounts, such as: <ul style="list-style-type: none"> • Processing transactions, mailing and auditing services • Administering insurance coverage, product, services or claims • Providing information to credit bureaus • Protecting against fraud • Responding to court/governmental orders or subpoenas and legal investigations • Responding to insurance regulatory authorities
Affiliates	Financial or nonfinancial companies related by common ownership or control. <ul style="list-style-type: none"> • <i>Company affiliates include insurance and non-insurance companies under common ownership with the Company and that provide insurance and non-insurance products or services.</i>

Non-affiliates	<p>Financial or nonfinancial companies not related by common ownership or control. We do not rent or sell your nonpublic personal information. However, we may share your information with companies that we hire to perform business services for us, such as data processing, computer software maintenance and development, and transaction processing. When we disclose information to others to perform these services, they are required to take appropriate steps to protect this information and use it only for purposes of performing the business services.</p> <ul style="list-style-type: none"> • <i>Company does not share information with non-affiliates to market to you.</i>
Joint marketing	<p>A formal agreement between non-affiliated financial companies that together market financial products or services to you.</p> <ul style="list-style-type: none"> • <i>Company does not jointly market.</i>

Changes to this Privacy Notice; contact us	<p>We may change the policies, standards and procedures described in this Notice at any time to comply with applicable laws and/or to conform to our current business practices. We will notify you of material changes.</p> <p>If you have any questions about your contract with us, you should contact your agent.</p> <p>If you have questions specific to our Privacy Notice, contact our Privacy Office via mail (Zurich – Privacy Office, 1299 Zurich Way, Schaumburg, IL 60196) or via email at privacy.office@zurichna.com.</p>
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This Privacy Notice is sent on behalf of the following affiliated companies:

American Guarantee and Liability Insurance Company, American Zurich Insurance Company, Colonial American Casualty and Surety Company, Empire Fire & Marine Insurance Company, Empire Indemnity Insurance Company, The Fidelity and Deposit Company of Maryland, Steadfast Insurance Company, Universal Underwriters Insurance Company, Universal Underwriters of Texas Insurance Company, Zurich American Insurance Company, Zurich American Insurance Company of Illinois, The Zurich Services Corporation (hereinafter individually and collectively referred to as "Company").



May 6, 2019

Moises Jimenez
3815 N. Kitley Avenue
Indianapolis, IN 46226

Re: Claim Number: 7370067050
Insured: The TJX Companies
Policy: GTU 4379556
Date of Loss: 7/20/18
Claimant: Moises Jimenez

Dear Mr. Jimenez,

This correspondence is being sent on behalf of Zurich American Insurance Company.

We have completed our review of the claim for benefits under the above referenced policy. Regrettably, for the reasons set forth below, we have determined that no benefits are payable in response to your claim.

The TJX Companies, Inc. maintains a benefit plan for accidental death and dismemberment benefits under Policy number GTU 4379556 issued by Zurich. The policy also provides dismemberment benefits in the event of a loss resulting from an injury.

The policy provides benefits in the event of a loss resulting from an injury defined by the policy as follows:



"Accident or Accidental means a sudden, unexpected, specific and abrupt event that occurs by chance at an identifiable time and place during the **Policy** term."

"Covered Accident means an **Accident** that results in a **Covered Loss**."

Covered Injury means an **Injury** directly caused by accidental means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under this **Policy**, and results in a **Covered Loss**

"Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**."

Policy number GTU 4379556 provides dismemberment benefits for the following:

8. Thumb and Index Finger of the same Hand 25% of Principal Sum

Covered Loss means. Actual severance through or above the metacarpophalangeal joint of a thumb or index finger

In order to conduct a complete review of your claim for benefits, we reviewed the following documents:

- Claim form
- The TJX Policy
- Attending physician statement
- EMS report
- Medical records from Eskenazi Hospital
- Medical records from Dr. Adkinson
- Independent medical review by Dr. John Siegert

According to the medical records from Dr. Adkinson and Eskenazi Hospital, you had multiple fingers amputated which included the thumb and index finger. We sent the records to Dr. John Siegert for an independent medical review. He reviewed the records and states that the thumb amputation was at the level of the interphalangeal joint. We sent the report to Dr. Adkinson for comment. He agrees with Dr. Siegert's findings.

According to the policy language, the benefit is for actual severance through and above the metacarpophalangeal joint of the thumb and index finger. Based on our review of all the medical records including the review from Dr. Siegert and Dr. Adkinson, the severance was not through the metacarpophalangeal joint of the thumb and therefore, a **Covered Loss** due to a **Covered Injury** did not occur.

While we believe our position to be correct, we understand that you may disagree with our decision. Therefore, in accordance with the rules and regulations of the Employee Retirement Income Security Act, which governs this plan, you have the right to appeal



our decision to deny the dismemberment benefit. You have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor Regulations. Your appeal should provide in writing your reason for disagreeing with our decision, and should include supplemental documentation that will have a bearing on our decision. The appeal must be received by us within 60 days of the date you receive this letter.

A decision on appeal will be made no later than 60 days after we receive your written request for review of the initial determination. The review will take into account all new information, whether or not presented or available at the initial determination. If we determine that special circumstances require an extension of time for a decision on appeal, the review period may be extended by an additional 60 days (120 days in total). We will notify you in writing if an additional 60 day extension is needed.

In accordance with Section 502(a) of ERISA, you have the right to bring a civil action following an adverse benefit determination, but you must complete this appeal procedure before filing suit. If we do not receive your written appeal within 60 days of the date you receive this letter, our claim determination will be final. The policy under which you are insured for this claim has a provision, which states, in part, that no lawsuit or legal action shall be brought to recover on the policy after the expiration of three years from the time proof of loss is required.

Please direct your appeal to:

Zurich American Insurance Company
P. O. Box 968041
Schaumburg, IL 60196-8041

Attn: Kathy Kelsch
ERISA Appeal Committee
Technical Claims Division
A&H Special Risk Claims

Zurich reserves the right to assert any and all claims and defenses that it may have, whether or not expressly stated herein or in any other correspondence.

Very truly yours,

Kathy Kelsch
Claims Specialist III
Accident & Health Special Risk Claims
Technical Claims Division



Zurich N.A. Insurance Company
P. O. Box 968041
Schaumburg, IL 60196-8041
Phone: (201) 209-4726
Fax: (866) 255-2962
Kathy.kelsch@zurichna.com





JAMES A. GOODIN, III
JAMES ABERNATHY
PAUL C. POPOWICZ
CHRISTOPHER F. CLARK
JAMES P. BROWNE, JR.
ANDREW B. JARATOLLO
ARACELI F. AUSSER

GOODIN ABERNATHY LLP

ATTORNEYS AT LAW

WRITER'S DIRECT E-MAIL:
jbrowne@goodinabernathy.com

July 3, 2019

Zurich American Insurance Co.
P.O. Box 968041
Schaumburg, IL 60196-041

ATTN: Kathy Kelsch
ERISA Appeal Committee
Technical Claims Division
A&H Special Risk Claims
CLAIM 7370067050
Insured The TJX Companies

Dear Ms. Kesch:

I represent your Moises Jimenez and his mother for an accidental dismemberment claim under your policy GTU 4379556. You sent a claim denial letter to Moises, basically claiming there was insufficient hand and finger amputation to be considered a covered injury or loss under your policy. PLEASE ACCEPT THIS APPEAL OF THE DENIAL.

According to your denial letter, you allege the amputation standard for is "actual severance through and above the metacarpophalangeal joint¹ of the thumb *and* index finger." In support, you cite opinions from two doctors but did not supply their reports or any detail of the opinions.

However, this does not matter as much because your position is LEGALLY insufficient. So much so, that your proposed analysis approaches a bad faith interpretation of your own policy terms. Please review the Definitions section of your Accidental Dismemberment and Covered Loss of Use Benefit. For convenience I am supplying you with the circled section as Exhibit B. In this section, the policy language is importantly different from the phrase you cite. The actual definition states:

"Covered Loss" means: Actual severance through or above the metacarpophalangeal joint of a thumb or index finger.

The policy term considers the severance of the thumb "OR" index finger. *Your interpretation tries to change the standard by including a severance of both the thumb AND index finger.*

Obviously this detail is important for two reasons. First, Indiana law pays attention to the exact language of insurance policies and weighs in favor of the insured / beneficiary for any ambiguous terms or

¹ See Diagram marked Exhibit A.

phrases. If there are competing terms or conditions in a policy, Indiana's law also finds in favor of the insured / beneficiary.

Really, the condition stated in your Definitions section is unambiguous. The claim is covered if severance occurs through the "thumb **OR** index finger." Your denial and the alleged medical opinions only focus on the thumb amputation. It does not acknowledge the index finger amputation alone satisfies the policy's terms.

I am including, again for quick reference, a picture of my client's hand as Exhibit C. Clearly his index finger was amputated below the metacarpophalangeal joint. Frankly I am disappointed with the pivot your own denial letter uses. First, you correctly cite the definition of a Covered Loss and acknowledge the severance can be located at the thumb **OR** index finger. Later, for your denial, you actually *change that language* in a way that a layperson probably would not identify. I trust this was a simple oversight.

I submit this Appeal for your group's consideration. This loss should be covered and your policy's benefits should be paid to my client. Please notify me of your decision and trust that absent some additional or new information regarding the stated policy terms, I will represent Mr. Jimenez for a civil action.

Thanks for your consideration.

Sincerely,

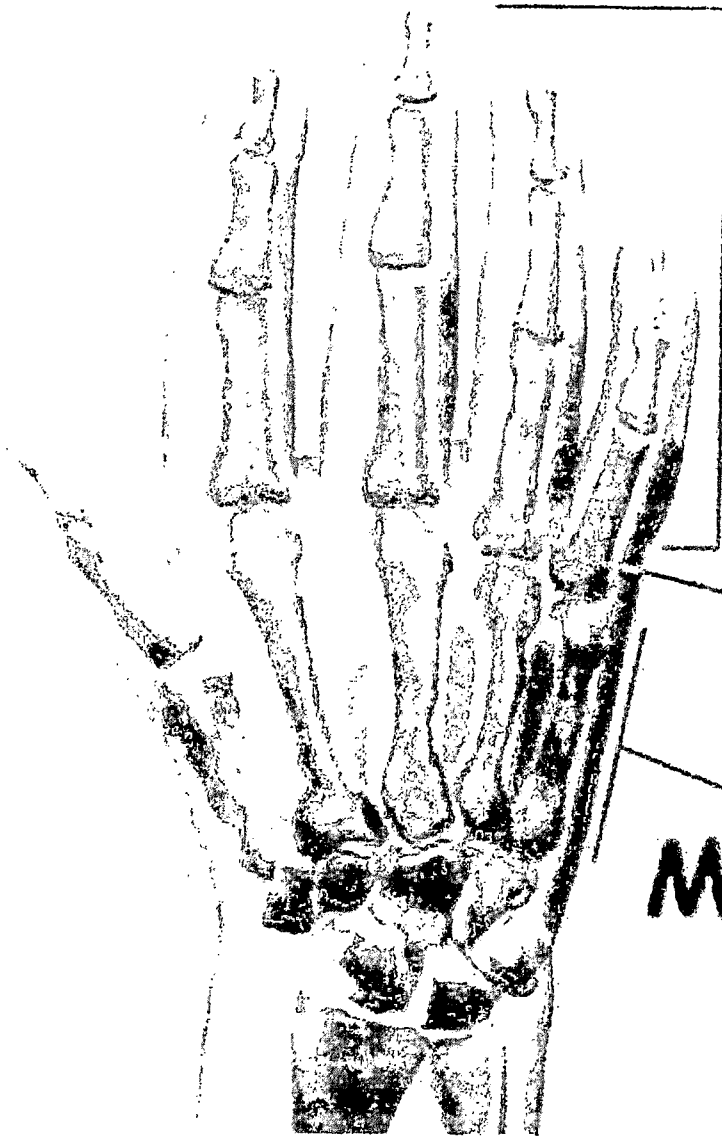
GOODIN ABERNATHY, LLP

A handwritten signature in black ink, appearing to read "James R. Browne Jr.", written over the printed name.

James R. Browne Jr.

Enclosures: Exhibits A, B & C

MCP Joints



Phalanges

Metacarpophalangeal joints

Metacarpals

EX. A

Accidental Death & Dismemberment (AD&D) Insurance

on which you reach age 70, 75, 80 and 85. For example, if your birthday is June 1 and your Premium Due Date falls on the first of each month, then your coverage will be reduced on June 1. However, if your birthday is June 15, then your coverage will be reduced on July 1. The reduced amount is determined by multiplying your full coverage amount (\$10,000, \$50,000, \$100,000, or \$200,000) by the applicable "Percentage of Coverage" shown in the table below.

Associate's Age	Percentage of Coverage	Associate's Age	Percentage of Coverage
Age 70 – 74	65%	Age 80 – 84	30%
Age 75 – 79	45%	Age 85 or over	15%

Benefit Payments**Accidental Death Benefit**

If a covered person suffers a loss of life as a result of a covered injury, Zurich will pay the applicable principal benefit. The death must occur within 365 days of the covered injury.

Accidental Dismemberment and Covered Loss of Use Benefit

If an injury to a covered person results in any of the following covered losses, Zurich will pay the benefit amount shown. The covered loss must occur within 365 days of the accident. The benefits will be paid as a percentage of your full coverage amount as follows:

Covered Loss of:	Percentage of Coverage the Plan will Pay:	Covered Loss of:	Percentage of Coverage the Plan will Pay:
Both Hands or Both Feet	100%	One Hand; One Foot; or Sight of One Eye	50%
One Hand and One Foot	100%	Thumb and Index Finger of the same Hand	25%
One Hand or One Foot plus the loss of Sight of One Eye	100%	Use of Four Limbs	150%
Sight of Both Eyes	100%	Use of Three Limbs	75%
Speech and Hearing	100%	Use of Two Limbs	66⅔%
Speech or Hearing	50%	Use of One Limb	50%

In the event you suffer more than one of the above losses in the same accident, the largest percentage of coverage indicated will be paid. If a covered person suffers an injury resulting in a covered loss, and he or she is covered under more than one class, Zurich will pay only one benefit, the largest benefit.

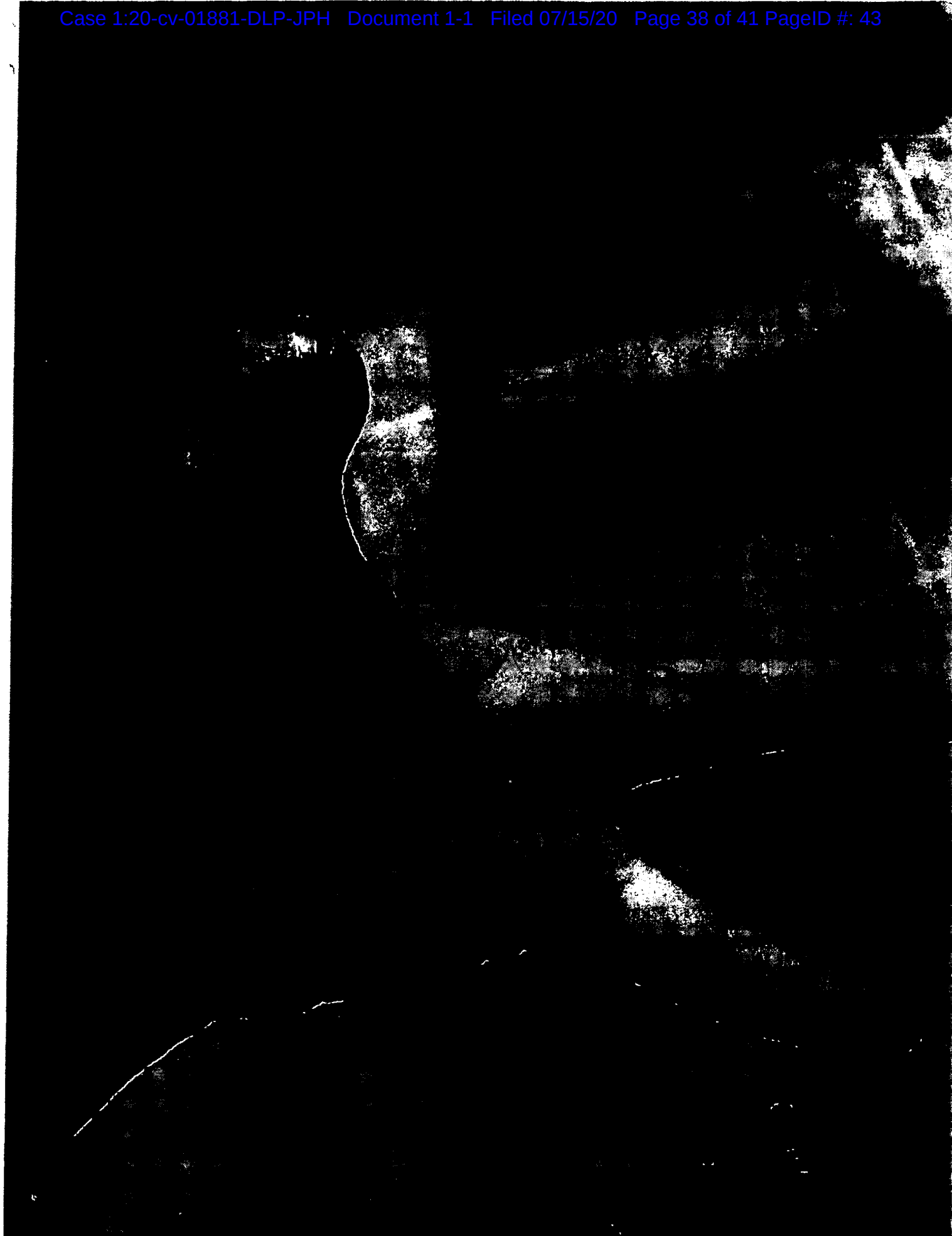
If loss of life is the result of an accident, a benefit for the full coverage amount will be paid to the beneficiary.

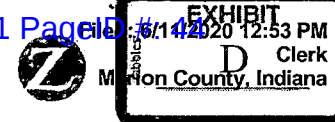
For purposes of this benefit:

- "Covered loss" means:
 - For a foot or hand, actual severance through or above an ankle or wrist joint;
 - Actual severance through or above the metacarpophalangeal joint of a thumb or index finger;
 - Total and permanent loss of sight;
 - Total and permanent loss of speech;
 - Total and permanent loss of hearing.

EX. **B**

Words in italics are defined in the section titled "Definitions."





ZURICH

August 26, 2019

Goodin Abernathy LLP
Attorneys at Law
301 E. 38th Street
Indianapolis, IN 46205
Attention: Mr. James R. Browne Jr.

Sent via Electronic Mail to jbrowne@goodinabernathy.com and Certified Mail

Re:	Your Client:	Moises Jimenez
	Claim Number:	7370067050
	Our Insured:	The TJX Companies
	Policy Number:	GTU 4379556
	Date of Accident:	7/20/18

Dear Mr. Browne,

Zurich

300 Interpace Parkway
Morris Corporate 1
Building B/C
Parsippany, NJ 07054

Phone (973)394-5291
maureen.sullivan@zurichna.com
www.zurichna.com

The ERISA Committee (the "Committee") has considered your appeal of the denial of the above referenced matter regarding your client's claim for dismemberment benefits under an accident policy issued to The TJX Companies, policy number GTU 4379556. In addition to reviewing the complete claim file in this matter, the Committee also reviewed your appeal letter with attachments dated 7/3/19 which was received by Zurich American Insurance Company on 7/3/19.

Following our review of the claim file and the appeal letter, the Committee affirms the denial of the claim for the reasons set forth in the Zurich letter of 5/6/19 as well as the reasons set forth in this letter.

The TJX Companies established and maintained an employee benefit plan, funded in part through Group Accident Policy number GTU 4379556 which was issued by Zurich American Insurance Company. Please refer to the policy provisions below:

SECTION V – BENEFITS

ACCIDENTAL DISMEMBERMENT AND COVERED LOSS OF USE BENEFIT

If an **Injury** to a **Covered Person** results in any of the following **Covered Losses**, We will pay the benefit amount shown. The **Covered Loss** must occur within 365 days of the **Accident**.

The benefit amounts are based upon the **Principal Sum** of the person suffering the **Covered Loss**.

Covered Loss of

8. Thumb and Index Finger of the same Hand 25% of **Principal Sum**

For purposes of this benefit:

1. **Covered Loss** means:

b. Actual severance through or above the metacarpophalangeal joint of a

Page 2

thumb or index finger;

SECTION III - DEFINITIONS

Covered Loss means a loss which meets the requisites of one or more benefits or additional benefits, results from a **Covered Injury**, and for which benefits are payable under this **Policy**.

Covered Injury means an injury directly caused by accidental means which is independent of all other causes, results from a **Covered Accident**, occurs while the **Covered Person** is insured under this **Policy**, and results in a **Covered Loss**.

In your appeal letter, you disagree with our rationale for denial and dispute that the policy language supports a denial of coverage.

A peer review was completed by Dr. John J. Siegert who opined that the left thumb was amputated at the level of the interphalangeal joint and not at the metacarpophalangeal level. The index finger was amputated at the metacarpal neck level.

Dr. Joshua Adkinson provided a medical opinion agreeing with Dr. Siegert; he further stated that the thumb amputation was at the level of the interphalangeal joint and the index finger was amputated at the level of the metacarpal shaft.

I would like to point out that in order to reach the definition of Covered Loss related to the dismemberment (1b above), the claim must first meet the definition of Covered Loss (8 above), in Section V – Benefits under Accidental Dismemberment and Covered Loss of Use Benefit.

Following our review of this file and your appeal, since Mr. Jimenez's amputations of the thumb and the index finger were not both at the metacarpophalangeal joint, the loss does not meet the definition of **Covered Loss** or **Covered Injury**.

For the reasons cited above and as originally stated in the denial letter, we inform you that we affirm the denial of benefits under the Policy.

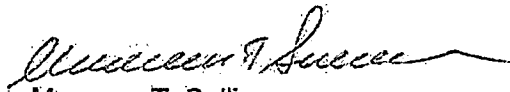
The Policy was issued to an employer for the benefit of its employees and therefore, claims under the Policy are governed by the Employment Retirement Income Security Act of 1974, as amended ("ERISA"). This letter constitutes a denial of your appeal under the Plan. You are entitled to receive, upon request and free of charge, copies of all documents, records and information relevant to this claim. You may consider bringing a civil action under Section 502(a) of ERISA if you choose to pursue this claim.

Page 3

Please direct any document request to:

Zurich American Insurance Company
P.O. Box 968041
Schaumburg, IL 60196-8041
Attention: Ms. Kathy Kelsch, Specialties Division, A&H Special Risk Claims

Sincerely,

A handwritten signature in black ink, appearing to read "Maureen T. Sullivan", with a long horizontal flourish extending to the right.

Maureen T. Sullivan
ERISA Committee Chair